FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040493

Facility Name: Fairmont Care Centre

Address: 5061 N. Pulaski Road (Number) Chicago (City) 60630 (Zip Code)

County: Cook

Telephone Number: (773) 604-8112 **Fax #** (773) 604-8113

IDPA ID Number: 36-3980966

Date of Initial License for Current Owners: 11-May-1995

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (770) 604-4416

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-Jan-04 to 31-Dec-04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 24th March 2005 (Date)
(Type or Print Name) Christopher Vicere
(Title) Vice President - Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds April 1st 2004

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	94	Skilled (SNF)	104	37,154	1
2		Skilled Pediatric (SNF/PED)			2
3	72	Intermediate (ICF)	72	26,352	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	166	TOTALS	176	63,506	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,400	3,929	5,512	21,841	8
9	SNF/PED					9
10	ICF	34,669	2,946	10	37,625	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,069	6,875	5,522	59,466	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.64%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11-May-1995

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11-May-1995 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 104 and days of care provided 4,995

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	389,892	47,105	9,480	446,477		446,477		446,477			1
2	Food Purchase		311,449		311,449	(20,255)	291,194	(324)	290,870			2
3	Housekeeping	251,787	37,468		289,255		289,255		289,255			3
4	Laundry	79,106	27,262		106,368		106,368		106,368			4
5	Heat and Other Utilities			271,672	271,672		271,672		271,672			5
6	Maintenance	61,385	40,247	99,446	201,078		201,078	(2,293)	198,785			6
7	Other (specify):*											7
8	**TOTAL General Services**	782,170	463,531	380,598	1,626,299	(20,255)	1,606,044	(2,617)	1,603,427			8
	B. Health Care and Programs											
9	Medical Director			28,800	28,800		28,800		28,800			9
10	Nursing and Medical Records	2,574,775	282,448	158,692	3,015,915		3,015,915		3,015,915			10
10a	Therapy											10a
11	Activities	159,423	20,338		179,761		179,761		179,761			11
12	Social Services	95,241		1,379	96,620		96,620		96,620			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Dental Service*			641	641		641		641			15
16	**TOTAL Health Care and Programs**	2,829,439	302,786	189,512	3,321,737		3,321,737		3,321,737			16
	C. General Administration											
17	Administrative	85,309		301,890	387,199		387,199	(221,977)	165,222			17
18	Directors Fees											18
19	Professional Services			33,911	33,911		33,911	7,472	41,383			19
20	Dues, Fees, Subscriptions & Promotions			64,449	64,449		64,449	(42,536)	21,913			20
21	Clerical & General Office Expenses	143,796	31,624	45,075	220,495		220,495	84,683	305,178			21
22	Employee Benefits & Payroll Taxes			606,830	606,830	20,255	627,085	48,466	675,551			22
23	Inservice Training & Education			804	804		804		804			23
24	Travel and Seminar			3,975	3,975		3,975	6,167	10,142			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			9,925	9,925		9,925		9,925			26
27	Other (specify):* Payroll Taxes (Sch.VII)**							11,632	11,632			27
28	**TOTAL General Administration**	229,105	31,624	1,066,859	1,327,588	20,255	1,347,843	(106,093)	1,241,750			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,840,714	797,941	1,636,969	6,275,624		6,275,624	(108,710)	6,166,914			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Fairmont Care Centre #0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			105,114	105,114		105,114	369,623	474,737			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,601	5,601		5,601	811,228	816,829			32
33	Real Estate Taxes			166,250	166,250		166,250		166,250			33
34	Rent-Facility & Grounds			1,920,000	1,920,000		1,920,000	(1,920,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,196,965	2,196,965		2,196,965	(739,149)	1,457,816			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		160,684	306,694	467,378		467,378		467,378			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			95,259	95,259		95,259		95,259			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		160,684	401,953	562,637		562,637		562,637			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,840,714	958,625	4,235,887	9,035,226		9,035,226	(847,859)	8,187,367			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	204,818	30		9
10	Interest and Other Investment Income	(2,311)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(324)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(4,608)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(375)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,674)	21		24
25	Fund Raising, Advertising and Promotional	(66,314)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,662)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(660)	20		28
29	Other-Attach Schedule *Page 5A attached	(2,293)	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 105,597		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(953,456)	6 & 6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (953,456)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (847,859)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Fairmont Care Centre

ID# 0040493

Report Period Beginning: 1-Jan-04

Ending: 31-Dec-04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance Cost (incurred in 2004)	$ (4,715)	6	1
2	Deferred Maintenance Cost (allocated for 2004)	2,422	6	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,293)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(324)	0	0	0	0	0	0	0	0	0	0	(324)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(2,293)	0	0	0	0	0	0	0	0	0	0	(2,293)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,617)	0	0	0	0	0	0	0	0	0	0	(2,617)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(221,977)	0	0	0	0	0	0	0	0	0	(221,977)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,007	1,465	0	0	0	0	0	0	0	0	7,472	19
20	Fees, Subscriptions & Promotions	(67,349)	24,013	800	0	0	0	0	0	0	0	0	(42,536)	20
21	Clerical & General Office Expenses	(22,336)	100,957	6,062	0	0	0	0	0	0	0	0	84,683	21
22	Employee Benefits & Payroll Taxes	0	48,466	0	0	0	0	0	0	0	0	0	48,466	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,167	0	0	0	0	0	0	0	0	0	6,167	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	11,632	0	0	0	0	0	0	0	0	0	11,632	27
28	**TOTAL General Administration**	(89,685)	(24,735)	8,327	0	0	0	0	0	0	0	0	(106,093)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(92,302)	(24,735)	8,327	0	0	0	0	0	0	0	0	(108,710)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fairmont Care Centre # 0040493 **Report Period Beginning:** 1-Jan-04 **Ending:** 31-Dec-04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	200,210	673	168,740	0	0	0	0	0	0	0	0	369,623	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,311)	31,329	782,210	0	0	0	0	0	0	0	0	811,228	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(1,920,000)	0	0	0	0	0	0	0	0	(1,920,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	197,899	32,002	(969,050)	0	0	0	0	0	0	0	0	(739,149)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	105,597	7,267	(960,723)	0	0	0	0	0	0	0	0	(847,859)	45

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Officers' Salaries	$	Lancaster, Ltd.	100.00%	$ 56,123	$ 56,123	1
2	V	27	Payroll Taxes-Officers'		Lancaster, Ltd.	100.00%	2,571	2,571	2
3	V	17	Management Fee Income	301,890	Lancaster, Ltd.	100.00%		(301,890)	3
4	V	19	Professional Services		Lancaster, Ltd.	100.00%	6,007	6,007	4
5	V	21	Clerical Expenses		Lancaster, Ltd.	100.00%	100,957	100,957	5
6	V	22	Employee Benefits		Lancaster, Ltd.	100.00%	48,466	48,466	6
7	V	24	Education, Seminars & Travel		Lancaster, Ltd.	100.00%	6,167	6,167	7
8	V	17	Administrative Consultant		Lancaster, Ltd.	100.00%	23,790	23,790	8
9	V	20	Fees and Marketing		Lancaster, Ltd.	100.00%	24,013	24,013	9
10	V	32	Interest		Lancaster, Ltd.	100.00%	31,329	31,329	10
11	V	30	Depreciation		Lancaster, Ltd.	100.00%	673	673	11
12	V	27	Payroll Taxes-Clerical		Lancaster, Ltd.	100.00%	9,061	9,061	12
13	V								13
14	Total			$ 301,890			$ 309,157	$ * 7,267	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rental	$ 1,920,000	Fairmont Property, LLC		$	$ (1,920,000)	15
16	V	32	Interest	17,790	Fairmont Property, LLC		800,000	782,210	16
17	V	20	Licenses & Fees		Fairmont Property, LLC		800	800	17
18	V	30	Depreciation		Fairmont Property, LLC		168,740	168,740	18
19	V	19	Accounting Expenses		Fairmont Property, LLC		1,465	1,465	19
20	V	21	State Replacement tax		Fairmont Property, LLC		6,062	6,062	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,937,790			$ 977,067	$ * (960,723)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Laurence Zung	Executive Officer	Administrative	42.5%	see attached	5	10.42%	Lancaster	$ 23,302	17-7	1
2	Christopher Vicere	VP-Finance	Administrative	10.00%	see attached	5	10.42%	Lancaster	16,434	17-7	2
3	Cheryl Morris	VP-Operations	Administrative	5.00%	see attached	5	10.42%	Lancaster	16,387	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 56,123		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lancaster, Ltd.
Street Address: 5061 N. Pulaski Road
City / State / Zip Code: Chicago, IL 60630
Phone Number: (773) 604.4416
Fax Number: (773) 478.1192

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Laurence Zung	Hours Worked	48	7	$ 223,698	$ 223,698	5	$ 23,302	1
2	27	Laurence Zung	Hours Worked	48	7	8,867		5	924	2
3	17	Christopher Vicere	Hours Worked	48	7	157,762	157,762	5	16,434	3
4	27	Christopher Vicere	Hours Worked	48	7	7,911		5	824	4
5	17	Cheryl Morris	Hours Worked	48	7	157,315	157,315	5	16,387	5
6	27	Cheryl Morris	Hours Worked	48	7	7,905		5	823	6
7										7
8										8
9	19	Professional Services	Management Fees	2,360,020	7	46,963		301,890	6,007	9
10	21	Clerical Expenses	Management Fees	2,360,020	7	62,820		301,890	8,036	10
11	22	Employee Benefits	Management Fees	2,360,020	7	378,883		301,890	48,466	11
12	24	Education and Seminars	Management Fees	2,360,020	7	8,842		301,890	1,131	12
13	17	Administrative Consultant	Management Fees	2,360,020	7	185,978	185,978	301,890	23,790	13
14	20	Marketing	Management Fees	2,360,020	7	171,696	155,227	301,890	21,963	14
15	32	Interest	Management Fees	2,360,020	7	131,563		301,890	16,829	15
16	30	Depreciation	Management Fees	2,360,020	7	5,260		301,890	673	16
17	20	Licenses and Fees	Management Fees	2,360,020	7	16,029		301,890	2,050	17
18	24	Travel	Management Fees	2,360,020	7	39,372		301,890	5,036	18
19	21	Salaries-Clerical	Management Fees	2,360,020	7	726,412	726,412	301,890	92,921	19
20	27	Payroll Taxes-Clerical	Management Fees	2,360,020	7	70,836		301,890	9,061	20
21										21
22										22
23	32	Direct Interest							14,500	23
24										24
25	TOTALS					$ 2,408,113	$ 1,606,392		$ 309,157	25

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Harston Investments		X	Long Term Loan			$	$			$ 800,000	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank One		X	Working Capital							16,829	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 816,829	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 816,829	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Fairmont Care Centre **#** 0040493 **Report Period Beginning:** 1-Jan-04 **Ending:** 31-Dec-04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	190,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	176,350	2
3. Under or (over) accrual (line 2 minus line 1).	$	(13,650)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	179,900	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	166,250	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	178,617	8
	2000	180,668	9
	2001	185,366	10
	2002	187,445	11
	2003	176,350	12

** Accrual is based on 2003 Taxes, adjusted for inflation**

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairmont Care Centre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040493

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604-4416 FAX #: (773) 478-1192

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-11-300-009-0000	Long-Term Healthcare	$ 176,350.00	$ 176,350.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 176,350.00	$ 176,350.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 108,681 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Care Facility	218,869	1995	$ 685,000	1
2					2
3	TOTALS	218,869		$ 685,000	3

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	176		1995		$ 2,240,980	$ 57,462	20	$ 57,462	$	$ 984,421	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Canopy and Awning			1995	3,300	85	20	85		1,435	9
10	Intercom System			1995	1,844	47	20	47		772	10
11	Roof Exhausters			1996	2,136	55	20	55		786	11
12	Permanent Signage			1997	16,625	982	15	982		10,554	12
13	Fire Alarm			1997	68,600	1,759	20	1,759		21,526	13
14	Parking Lot Excavation			1997	45,000	2,657	15	2,657		28,939	14
15	Parking Lot Asphalt			1997	68,000	4,015	15	4,015		25,880	15
16	Concrete Curbs			1997	18,000	1,063	15	1,063		6,851	16
17	Phase I Expansion-Landscaping			1997	41,000	2,421	15	2,421		15,605	17
18	Site Sewer			1997	28,500	1,683	15	1,683		10,847	18
19	Phase I Expansion-Building			1997	1,218,394	27,835	20	108,562	80,727	584,596	19
20	Ceramic Tiled Hallway			1998	10,603	272	15	272		3,017	20
21	Electrical Enhancements			1998	6,210	159	15	159		1,767	21
22	Phase II-Landscape			1999	15,000	935	15	935		6,586	22
23	Site Sewer			1999	40,376	2,517	15	2,517		17,727	23
24	Fire Protection			1999	43,440	1,114	20	1,114		5,895	24
25	Excavation			1999	49,650	3,095	15	3,095		21,800	25
26	Phase II Expansion			1999	2,281,933	55,008	20	214,541	159,533	780,149	26
27	Electrical-Courtyard			2001	6,520	167	15	167		661	27
28	Building Roofing			2001	21,919	562	20	562		1,803	28
29	Garage Roofing			2001	7,500	192	20	192		616	29
30	Heating System			2001	17,965	461	15	461		1,479	30
31	Addition to Heating System			2002	8,561	1,070	20	856	(214)	1,926	31
32	Improvement to Heating System			2002	11,688	1,460	20	1,169	(291)	2,532	32
33	Parking Lot Expansion			2002	31,500	1,885	20	3,150	1,265	6,825	33
34	Garden Pond			2003	5,000	238	20	333	95	500	34
35	Installation of Boiler & Heating Pipes			2003	54,886	1,407	20	4,574	3,167	5,717	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,365,130	$ 170,606		$ 414,888	$ 244,282	$ 2,551,212	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 689,047	$ 67,533	$ 52,996	$ (14,537)	10	$ 219,587	71
72	Current Year Purchases	49,954	29,259	4,173	(25,086)	10	4,173	72
73	Fully Depreciated Assets	907,549	2,521	2,680	159	10	907,549	73
74								74
75	TOTALS	$ 1,646,550	$ 99,313	$ 59,849	$ (39,464)		$ 1,131,309	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,696,680	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 269,919	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 474,737	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 204,818	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,682,521	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Rental Property	$ 179,744	$ 4,608	$ 44,302	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 179,744	$ 4,608	$ 44,302	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Fairmont Property, LLC (a related entity)

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. ____
This amount was calculated by dividing the total amount to be amortized ____
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 127,116	$		$ 127,116	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			12,751			12,751	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			166,827			166,827	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				132,437		132,437	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
	** Medical Supplies	39-2					19,264		19,264	
13	Other (specify): **Specialty Bed Rental	39-2					8,983		8,983	13
14	TOTAL			$		$ 306,694	$ 160,684		$ 467,378	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Fairmont Care Centre # 0040493 **Report Period Beginning:** 1-Jan-04 **Ending:** 31-Dec-04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 31-Dec-04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,404	$ 4,906	1
2	Cash-Patient Deposits	65,550	65,550	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,858,830	1,858,830	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,080	37,080	6
7	Other Prepaid Expenses	575	575	7
8	Accounts Receivable (owners or related parties)	30,790	522,362	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,996,229	$ 2,489,303	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		685,000	13
14	Buildings, at Historical Cost		2,420,724	14
15	Leasehold Improvements, at Historical Cost	568,937	3,854,849	15
16	Equipment, at Historical Cost	1,255,540	1,383,726	16
17	Accumulated Depreciation (book methods)	(1,461,460)	(2,383,152)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	67,109	67,109	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): *Construction in Progress*		74,090	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 430,126	$ 6,102,346	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,426,355	$ 8,591,649	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 193,492	$ 193,492	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	65,550	65,550	28
29	Short-Term Notes Payable	556,177	322,125	29
30	Accrued Salaries Payable	423,464	423,464	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,504	12,504	31
32	Accrued Real Estate Taxes(Sch.IX-B)	179,900	179,900	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,431,087	$ 1,197,035	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		8,000,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,000,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,431,087	$ 9,197,035	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 995,268	$ (605,386)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,426,355	$ 8,591,649	48

***(See instructions.)**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,352,447	1
2	Restatements (describe):		2
3	**Adjustment in Book Depreciation for Taxation**	(38,876)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,313,571	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	577,533	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	54,164	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(950,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (318,303)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 995,268	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after consolidation	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,330,329)	1
2	Restatements (describe):		2
3	**Adjustment in Book Depreciation for Taxation**	905,268	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (425,061)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,538,256	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	131,419	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,850,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (180,325)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (605,386)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,528,916	1
2	Discounts and Allowances for all Levels	(1,168,768)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,360,148	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	856,372	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 856,372	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	129,990	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,658	19
20	Radiology and X-Ray	6,730	20
21	Other Medical Services	63,380	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 208,758	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,311	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,311	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental Income	185,170	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 185,170	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,612,759	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,626,299	31
32	Health Care	3,321,737	32
33	General Administration	1,327,588	33
	B. Capital Expense		
34	Ownership	2,196,965	34
	C. Ancillary Expense		
35	Special Cost Centers	467,378	35
36	Provider Participation Fee	95,259	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,035,226	40
41	**Income before Income Taxes (line 30 minus line 40)****	577,533	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 577,533	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.** **Cash Basis Taxpaye

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,873	2,091	$ 84,015	$ 40.18	1
2	Assistant Director of Nursing	3,771	3,961	100,595	25.40	2
3	Registered Nurses	38,940	42,124	1,137,988	27.02	3
4	Licensed Practical Nurses	879	894	17,848	19.96	4
5	Nurse Aides & Orderlies	107,956	117,260	1,193,548	10.18	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	14,300	15,525	159,423	10.27	10
11	Social Service Workers	6,501	7,002	95,241	13.60	11
12	Dietician					12
13	Food Service Supervisor	1,915	2,091	32,648	15.61	13
14	Head Cook	34,135	37,116	357,244	9.63	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,875	4,183	61,385	14.67	17
18	Housekeepers	24,975	27,431	251,787	9.18	18
19	Laundry	8,182	8,945	79,106	8.84	19
20	Administrator	1,955	2,091	85,309	40.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,293	10,335	143,796	13.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,128	2,213	40,781	18.43	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	260,678	283,262	$ 3,840,714 *	$ 13.56	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	226	$ 9,480	1-3	35
36	Medical Director	900	28,800	9-3	36
37	Medical Records Consultant	112	4,128	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	540	6,230	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	38	1,379	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,816	$ 50,017		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	6,016	$ 148,334	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	6,016	$ 148,334		53

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
William H. Pfeiffer	Administrator	N/A	$ 85,309
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 85,309

B. Administrative - Other

Description	Amount
Management Fees - Lancaster, Ltd.	$ 301,890
TOTAL (agree to Schedule V, line 17, col. 3)	$ 301,890
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Health Data Systems, Inc.	Data Processing	$ 4,049
Accu-Med Services Inc	Data Processing	2,700
E-Health Data Solutions,LLC	Data Processing	2,169
Richard Peelo & Associates	Accounting	2,250
Frost Ruttenberg & Rothblatt	Accounting	1,525
Personnel Planners, Inc.	Payroll Tax Consultant	135
Stone, Pogrund & Korey	Legal	8,680
Cynthia R. Farenga	Legal	1,000
Winston & Strawn	Legal	120
Patricia K. Hogan	Legal	808
Rehab. Management Systems	Health Finance Consultant	10,475
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 33,911

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,300
Unemployment Compensation Insurance	28,848
FICA Taxes	283,783
Employee Health Insurance	180,275
Employee Meals	20,255
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	16,200
Uniform Allowance	561
Retirement Plan Contribution	8,100
Dental Insurance	12,588
Employment Fees	20,175
Lancaster Allocation	48,466
TOTAL (agree to Schedule V, line 22, col.8)	$ 675,551

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 5,520
Advertising: Employee Recruitment	4,525
Health Care Worker Background Check	252
(Indicate # of checks performed 21)	
Licenses & Fees	8,731
Promotional Advertising	45,011
Dues & Subscriptions	35
Charitable Contributions	375
Lancaster Allocation	24,013
Fairmont Property Allocation	800
Less: Public Relations Expense	(21,963)
Non-allowable advertising	(44,726)
Yellow page advertising	(660)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,913

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	355
Lancaster Allocation	5,036
Seminar Expense	3,620
Lancaster Allocation	1,131
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,142

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Painting and Decorating	Jan-00	$ 4,221	3	$ 1,407	$ 1,407	$ 704	$	$	$	$	$	$
2	Painting and Decorating	Feb-00	10,169	3	3,390	3,390	1,695						
3	Painting and Decorating	Mar-00	606	3	202	202	101						
4	Painting and Decorating	Apr-00	2,192	3	730	730	366						
5	Painting and Decorating	Jul-00	241	3	80	80	41						
6	Painting and Decorating	Aug-00	592	3	198	198	98						
7	Painting and Decorating	Sep-00	2,588	3	863	863	431						
8	Painting and Decorating	Oct-00	8,123	3	2,707	2,707	1,355						
9	Painting and Decorating	Jul-02	4,909	3		819	1,636	1,636	818				
10	Painting and Decorating	Feb-04	2,742	3				457	914	914	457		
11	Painting and Decorating	Sep-04	1,973	3				329	657	657	330		
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 38,356		$ 9,577	$ 10,396	$ 6,427	$ 2,422	$ 2,389	$ 1,571	$ 787	$	$

Facility Name & ID Number Fairmont Care Centre # 0040493 **Report Period Beginning:** 1-Jan-04 **Ending:** 31-Dec-04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **45,961** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **95,259**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes (Refer pg 23A)** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **20,255** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

FAIRMONT CARE CENTRE, INC
Provider # 0040493
Report Period : January 1st., 2004 through December 31st. 2004.

Fairmont Care Centre, Inc. has rental property. Management was very strict in the accounting of this rental property. Maintenance workers have maintained detailed logs as to the exact hours that they have spent doing work at the rental property. The following represents a detail of the $ 185,170 of rental income as listed on page 19, line # 28 of the 2004 cost report :

Rental Income received		$218,770
Less :	Maintenance Salary & Employee Benefits	(6,458)
	Utilities	(5,521)
	Maintenance Supplies and Expense	(11,557)
	Furnishings and Improvements	(7,887)
	Insurance	(2,177)
	NET RENTAL INCOME	$185,170